SERFF Tracking Number:	*META-126266267*	*State:*	*Arkansas*
Filing Company:	*Metropolitan Life Insurance Company*	*State Tracking Number:*	*43225*
Company Tracking Number:	*B09-48 SB SB*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Group Life & Accident & Health Insurance*		
Project Name/Number:	*GEF09-1 HEA/B09-48 SB sb*		

Filing at a Glance

Company: Metropolitan Life Insurance Company

Product Name: Group Life & Accident & Health Insurance	SERFF Tr Num: META-126266267	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 43225
Sub-TOI: L08.000 Life - Other	Co Tr Num: B09-48 SB SB	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Sandra Bennett	Disposition Date: 08/18/2009
	Date Submitted: 08/13/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: GEF09-1 HEA	Status of Filing in Domicile: Disapproved
Project Number: B09-48 SB sb	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/18/2009	Explanation for Other Group Market Type:
	State Status Changed: 08/18/2009
Deemer Date:	Created By: Sandra Bennett
Submitted By: Sandra Bennett	Corresponding Filing Tracking Number: B09-48 SB sb

Filing Description:

Please see the cover letter for a more detail description of the submitted filing.

Company and Contact

Filing Contact Information

Susan Bajusz, Senior Contract Analyst

501 Route 22 908-253-2120 [Phone]

SERFF Tracking Number:	*META-126266267*	*State:*	*Arkansas*
Filing Company:	*Metropolitan Life Insurance Company*	*State Tracking Number:*	*43225*
Company Tracking Number:	*B09-48 SB SB*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Group Life & Accident & Health Insurance*		
Project Name/Number:	*GEF09-1 HEA/B09-48 SB sb*		

Bridgewater, NJ 08807

Filing Company Information

Metropolitan Life Insurance Company	CoCode: 65978	State of Domicile: New York
MetLife	Group Code: -99	Company Type: Life
1095 Avenue of the Americas	Group Name:	State ID Number:
New York, NY 10036-6796	FEIN Number: 13-5581829	
(212) 578-2211 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	50.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Metropolitan Life Insurance Company	$50.00	08/13/2009	29835941

SERFF Tracking Number:	*META-126266267*	*State:*	*Arkansas*
Filing Company:	*Metropolitan Life Insurance Company*	*State Tracking Number:*	*43225*
Company Tracking Number:	*B09-48 SB SB*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Group Life & Accident & Health Insurance*		
Project Name/Number:	*GEF09-1 HEA/B09-48 SB sb*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/18/2009	08/18/2009

SERFF Tracking Number:	*META-126266267*	*State:*	*Arkansas*
Filing Company:	*Metropolitan Life Insurance Company*	*State Tracking Number:*	*43225*
Company Tracking Number:	*B09-48 SB SB*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Group Life & Accident & Health Insurance*		
Project Name/Number:	*GEF09-1 HEA/B09-48 SB sb*		

Disposition

Disposition Date: 08/18/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*META-126266267*	*State:*	*Arkansas*
Filing Company:	*Metropolitan Life Insurance Company*	*State Tracking Number:*	*43225*
Company Tracking Number:	*B09-48 SB SB*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Group Life & Accident & Health Insurance*		
Project Name/Number:	*GEF09-1 HEA/B09-48 SB sb*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Supporting Document	NAIC Transmittal Document		Yes
Supporting Document	ARCERTREG19		Yes
Form	Health Questions Form		Yes

SERFF Tracking Number:	*META-126266267*	*State:*	*Arkansas*
Filing Company:	*Metropolitan Life Insurance Company*	*State Tracking Number:*	*43225*
Company Tracking Number:	*B09-48 SB SB*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Group Life & Accident & Health Insurance*		
Project Name/Number:	*GEF09-1 HEA/B09-48 SB sb*		

Form Schedule

Lead Form Number: GEF09-1 HEA

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GEF09-1 HEA	Other	Health Questions Form	Initial		51.260	GEF09-1 John Doe 06-18-2009.pdf

[HEALTH INFORMATION]

[Section 1

To be completed:

- If you are enrolling for the first time, for any amount exceeding $50,000.
- If you are currently enrolled, for any amount exceeding $200,000]

[Please complete all questions below. Omitted information will cause delays.] [In this section, "you" and "your" refers to the person for whom insurance is being requested.]

[Your name John Doe Employee's Social Security/Identification # 123-45-6789

1. Your height 6 feet 1 inches Your weight 178 pounds

	Yes	No
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	☐	☒
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☒
4. Are you now, or have you in the past 5 years, used tobacco in any form? If "yes", check all that apply: ☐ cigarettes ___ packs per day ☐ cigar or pipe ☐ smokeless tobacco (dip, chewing) ☐ other: _____	☐	☒
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☒
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	☐	☒
7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	☐	☒
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☒
9. Have you been Hospitalized as defined below (not including well-baby delivery) in the past 90 days?	☐	☒
Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.		
10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐	☒

11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

	Yes	No
a. cardiac or cardiovascular disorder?	☐	☒
b. stroke or circulatory disorder?	☐	☒
c. high blood pressure?	☐	☒
d. cancer, Hodgkins disease, lymphoma or tumors? Indicate type _____	☐	☒
e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☒
f. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☒
g. asthma, COPD, emphysema or other lung disease? Indicate /type _____	☐	☒
h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☒
i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☒
j. memory loss?	☐	☒
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____	☐	☒
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐	☒
m. multiple sclerosis, ALS or muscular dystrophy?	☐	☒
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☒
o. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☒
p. back, neck, knee, spinal, joint or other musculosketal disorder?	☐	☒
q. carpal tunnel syndrome?	☐	☒
r. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☒
s. thyroid or other gland disorder? Indicate type _____	☐	☒
t. mental, anxiety, depression, attempted suicide or nervous disorder?	☐	☒
u. sleep apnea	☐	☒]

[For "yes" answers, please provide full details on the next page in Section 2.]

[Section 2] – [Please provide full details below for each "Yes" answer to the preceding questions 1- 11. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.]

[Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes _____ ☐ No
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Personal Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (___) ___-_____

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes _____ ☐ No
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Personal Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (___) ___-_____

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes _____ ☐ No
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Personal Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (___) ___-_____]

[Section 3]

[1. Personal Physician's Name: Jerome Doctor

Date of last visit: 1/4/2009 Reason for visit: routine physical

Address 1313 Pumpkin Lane Any town NJ 09432

Street City State Zip Code

Telephone: (123) 456 - 789

2. Are you currently taking any other prescribed medications? ☐ Yes ☒ No

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____

Address _____

Street City State Zip Code

Telephone: (___) ___-_____]

[If you answered "Yes" to any of the above questions, you must also complete and attach a Statement of Health form.]

[FRAUD WARNINGS]

[Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.]

[Arkansas, District of Columbia, Louisiana, New Mexico, Ohio, Oregon and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Fraudulent insurance act. No person shall, with intent to defraud: present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact; or present or cause to be presented any information which contains false representations as to any material fact or which conceals a material fact concerning the solicitation for sale of any insurance policy or purported insurance policy, an application for certificate of authority, or the financial condition of any insurer.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

Note: Dependent insurance is payable to the Employee.
If you have previously designated a beneficiary under your employer's plan, such beneficiary designation will remain in effect. Any MetLife payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below.
I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death.
I understand I have the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Jane Doe	spouse	11/16/1961	1313 Pumpkin Lane AnyTown NJ 09432	100
Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).			TOTAL:	100%

If all of the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).			TOTAL:	100%]

[DECLARATIONS AND SIGNATURE(S)]

[By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life or disability coverage during the initial enrollment period, or if I do not enroll for the maximum amount of life or disability coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase. I also understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.]

[_____ John Doe_____ 6/16/2009_____
Employee Signature — Print Name — Date Signed (Mo./Day/Yr.)]
[The employee must sign in all cases.]
[The employee must sign if the employee is not to be the owner]

[_____ _____ _____
Owner Signature (if other than the employee) — Print Name — Date Signed (Mo./Day/Yr.)

Proposed Insured(s) if other than employee and at least 18 years of age:

_____ _____ _____
Other Signature — Print Name — Date Signed (Mo./Day/Yr.)

_____ _____ _____
Other Signature — Print Name — Date Signed (Mo./Day/Yr.)]

SERFF Tracking Number:	*META-126266267*	*State:*	*Arkansas*
Filing Company:	*Metropolitan Life Insurance Company*	*State Tracking Number:*	*43225*
Company Tracking Number:	*B09-48 SB SB*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Group Life & Accident & Health Insurance*		
Project Name/Number:	*GEF09-1 HEA/B09-48 SB sb*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
GEF09-1
Attachment:
ARCERTREAD.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: The requireement listed above is not applicable
Comments:

Item Status: **Status Date:**

Satisfied - Item: Cover Letter
Comments:
Cover Letter
Attachment:
AR Filing Letter Final.pdf

Item Status: **Status Date:**

Satisfied - Item: NAIC Transmittal Document
Comments:
NAIC Transmittal Document
Attachment:
NAIC Transmittal Document 6-09 rev.pdf

Item Status: **Status Date:**

SERFF Tracking Number:	*META-126266267*	*State:*	*Arkansas*
Filing Company:	*Metropolitan Life Insurance Company*	*State Tracking Number:*	*43225*
Company Tracking Number:	*B09-48 SB SB*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Group Life & Accident & Health Insurance*		
Project Name/Number:	*GEF09-1 HEA/B09-48 SB sb*		

Satisfied - Item: ARCERTREG19

Comments:

ARCERTREG19

Attachment:

ARCERTREG19.pdf

MetLife®

Metropolitan Life Insurance Company
NAIC Company Number: 65978
NAIC Group Number: 241

ARKANSAS FLESCH CERTIFICATION

I certify that the form shown below has achieved the Flesch Reading Ease Score shown below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form No.	Form Description	Flesch Score
GEF09-1 HEA, et.al	Enrollment Form	51.26

Herbert B. Brown Jr.
Vice President

ARCERTREAD

Metropolitan Life Insurance Company
501 U.S. Highway 22 West, Area 3W
Bridgewater, NJ 08807
Tel 908 253-2120 Fax 908 253-2126
sbajusz@metlife.com

Susan Bajusz
Senior Contract Consultant
Institutional Contracts Development

MetLife®

August 13, 2009

Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, Arkansas 72201-1904

Re: Group Life and Accident & Health Insurance
Enrollment Form
Our NAIC Company No. is 65978
Our FEIN is 13-5581829
Our Filing Number B09-48 SB

Dear Sir/Madam:

We enclose for filing final printed copies of the forms described below.

GEF09-1 HEA	Health Questions Form. This form is substantially similar to the medical questions form GEF02-1 MQ, previously approved by your Department on 9/12/2002. This form will be used to gather the health information necessary to underwrite the risk. The formatting of the medical questions may appear in any order or combination, may be asked of one or more individuals or any of the questions may be omitted. In those questions that reflect multiple medical conditions, some medical conditions may also be omitted.
GEF09-1 FW	Fraud Warning Form. This form will be used to provide the applicable fraud warning disclosures to the proposed insured.
GEF09-1 DEC	Enrollment Form Declarations Page. This form is substantially similar to Declarations page GEF02-1a DEC, previously approved by your Department on 9/26/2003. This form is designed to designate a beneficiary, to confirm the accuracy of the proposed insured's information, to confirm the proposed insured's understanding of the key aspects of a policyholder's plan including payroll deductions, dependent coverage, to confirm review and receipt of the fraud warnings (as applicable) and to provide a signature block for the proposed insured's signature.

Each of the forms described above will be used in conjunction with the GEF02-1 ADM previously approved by your Department on 9/2/2002. The forms may be used individually or in combination with one another. For example, if a policyholder's plan allows us to enroll individuals without having to ask any of the medical questions included on GEF09-1 HEA then only Forms GEF02-1 ADM, GEF09-1 FW and GEF09-1 DEC will be used. These forms may be used in conjunction with any eligible group for which group life and/or accident and health insurance is to be provided and under any group policy and certificate forms previously approved by your Department as well as any of our group policy and certificate forms that may be approved in the future. Each form has been designed to gather and/or provide the specific information as described above. Variable material is indicated by brackets.

Formatting Conventions

The use of sections and subsections may be added or may vary. Section title, Page and section references and question numbers are illustrative. The font size and style but in no event will the text appear in less than 10 point type.

If we remove or add bulleted, numbered or lettered variable items, formatting and grammar will be adjusted accordingly.

The form may be produced to appear in a continuous text or a booklet format. It may also be made available in an electronic format. The formatting may change when made available in an electronic format.

We may change the term “Enrollment Form” if these forms are to be used for other than an initial enrollment or to match a policyholder’s plan design. For example, the form may vary to request changes in coverage or, if the form focuses on the gathering of health information through the medical questions, the references to “Enrollment Form” may be replaced by “Statement of Health”.

The terminology will be adjusted appropriately throughout the form to reflect the nature of the group such as “Employer”, “Policyholder”, “Trust”, “Labor Union or Association.” In addition, the terminology may be replaced with the term, “Contractholder”, “Group”, “Group Customer”, “Third Party Administrator”, “TPA”, “Recordkeeper” or other appropriate term and may vary to replace the terms with the names of these entities. In addition, terms such as “Employer” may be replaced with the terms used in the underlying certificate. If changed, grammar may be adjusted accordingly.

The term “Employee” may be replaced with another appropriate term such as “Member”, “Associate”, “Partner” “Certificateholder, “Subscriber”, “Participant”, “Retiree”, “Insured”, “Covered Person” or other appropriate term to reflect the terminology used in the underlying certificate.

Coverage names and types are illustrative. The term “coverage” may be replaced with the term “insurance” or reflect the actual coverage name used in the underlying certificate.

Bracketed references to a single individual may be revised to reference multiple individuals in situations such as when there is an owner other than the employee. In addition, if coverage is requested for more than one individual, appropriate formatting changes will be made throughout the forms.

References to periods of time or dollar amounts mandated by state or federal laws will vary to conform to changes in such laws.

Contact information for administration offices, such as unit names, addresses and telephone numbers, may vary to accommodate the Employer’s plan and their and MetLife’s administrative system needs.

The enclosed form~~s~~ may be translated into a language other than English. Any such translation will be performed by a professional translation service, and we will obtain certification from such service that the forms, as translated, are an accurate representation of the English language versions. The non-English version of each form will include a disclosure in the foreign language indicating that the non-English version is a translation of an English language form, and that in any conflict that may arise between the English and translated versions, the English language version of the form will control.

The officer signing below certifies that the enclosed form achieves a Flesch Reading Ease Score of 51.26.

If you have any questions or comments please feel free to contact me.

Very truly yours,

Susan Bajusz
Senior Consultant

Herbert B Brown, Jr.
Vice President

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	MetLife Institutional Contracts, MSC 39087 1095 Ave. of the Americas NY,NY 10036-6796	NY	Life and Health	241	65978	13-5581829	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Susan Bajusz Metropolitan Life Insurance Co. 501 Route 22, Area 02C-312B Bridgewater Twnsp. NJ 08807	(908) 253-2606	(908) 253-2126	sbajusz@metlife.com

5.	Requested Filing Mode	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	Company Tracking Number	B09-48 SB
7.	☒ New Submission ☐ Resubmission	Previous file # _____
8.	Market	☐ Individual ☐ Franchise Group: ☐ Small ☐ Large ☒ Small and Large ☒ Employer ☒ Association ☒ Blanket ☐ Discretionary ☐ Trust ☒ Other: Labor Union_____
9.	Type of Insurance (TOI)	L08 Life – Other, H21Health –Other
10.	Sub-Type of Insurance (Sub-TOI)	L08.000 Life –Other, H21.000 Health - Other
11.	Submitted Documents	☒ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other **Rates** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other_____

12.	**Filing Submission Date**	**August 13, 2009**			
13	**Filing Fee (If required)**	Amount 50.00		Check Date	EFT
		Retaliatory ☐ Yes ☐ No		Check Number	EFT
14.	**Date of Domiciliary Approval**	**Concurrently being filed in all states**			
15.	**Filing Description: PLEASE SEE COVER LETTER**				

16.	**Certification (If required)**

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name **Susan Bajusz** Title **Senior Contract Consultant**

Signature  Date: **July 25, 2009**

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	B09-48 SB
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	Enrollment Form	GEF09-1	☒ Initial ☐ Revised ☐ Other _____	
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	

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18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number			**N/A**	
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing			**%**	
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
02			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
03			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
04			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
05			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
06			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
07			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
08			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
09			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
10			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	

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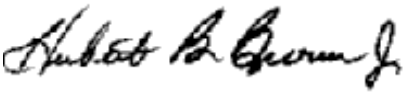
MetLife®

Metropolitan Life Insurance Company
NAIC Company Number: 65978
NAIC Group Number: 241

ARKANSAS CERTIFICATION
Rule and Regulation 19
Unfair Sex Discrimination in the Sale of Insurance

I certify that this submission meets the provisions of Rule and Regulation 19, and all applicable requirements of the Arkansas Department of Insurance.



Herbert B. Brown Jr.
Vice President

ARCERTREG19